SUMMARY OF BENEFITS

Connecticut General Life Insurance Co.

Maricopa County
Cigna Choice Fund Medical Plan with Health Savings Account
Preferred Provider Organization Coinsurance Plan

Health Savings Account			
Your coverage includes a health savings account that you can use to pay for eligible out-of-pocket expenses.			
Employer Contribution	**Employee** $500	**Employee + 1** $1,000	**Family** $1,000

Annual deductibles and maximums	In-network	Out-of-network
Lifetime maximum	Unlimited per individual	
Pre-Existing Condition Limitation (PCL)	Applies	Applies
Coinsurance	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met

Maximum Reimbursable Charge
• Determined based on the lesser of:
  • the health care professional's normal charge for a similar service; or
  • a percentage of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area.
• In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is determined based on the lesser of:
  • the health care professional's normal charge for a similar service or supply; or
  • the amount charged for that service by 80% of the health care professionals in the geographic area where it is received.
• Out-of-network services are subject to a contract year plan deductible and maximum reimbursable charge limitations.
	N/A	110%

Annual deductibles and maximums	In-network	Out-of-network
Contract year plan deductible • The amount you pay for any expenses counts towards both your in-network and out-of-network plan deductibles. (Cross accumulation). • All family members contribute towards the family plan deductible. The plan cannot pay an individual's claims until the total family plan deductible has been met, even if he or she has met the individual plan deductible. • This plan includes a combined Medical/Rx plan deductible. • Retail and home delivery pharmacy costs contribute to the plan deductible. • Once the combined medical/Rx plan deductible has been met, pharmacy will be paid at the defined pharmacy levels.	**Individual** $1,200 **Individual and Family** $2,400	**Individual** $1,200 **Individual and Family** $2,400
Contract year out-of-pocket maximum • The amount you pay for any services counts towards both your in-network and out-of-network out-of-pocket maximums. (Cross accumulation) • Plan deductibles contribute towards your out-of-pocket maximum. • Copays do not contribute towards your out-of-pocket maximum • Mental health and substance abuse services contribute towards your out-of-pocket maximum. • All family members contribute towards the family out-of-pocket maximum. The plan cannot pay an individual's covered expenses at 100% until the total family out-of-pocket maximum has been reached. • This plan includes a combined Medical/Rx out-of-pocket maximum. • Retail and home delivery pharmacy costs contribute to the out-of-pocket maximum.	**Individual** $2,000 **Individual and Family** $4,000	**Individual** $2,000 **Individual and Family** $4,000

Benefits	In-network	Out-of-network
Physician services		
Office visit • Primary care physician and specialist office visits	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Convenience Care Visit	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met

Benefits	In-network	Out-of-network
Physician services (hospital) • In hospital visits and consultations • Inpatient services • Outpatient services	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Surgery (in a physician's office)	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Preventive care		
Preventive care • Includes well-baby, well-child, well-woman and adult preventive care • Includes immunizations • Includes lab and x-ray billed by the doctor's office	No charge, no plan deductible	Not covered
Mammogram, PSA, Pap Smear and Maternity Screening • Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.	No charge, no plan deductible	You pay 30% Plan pays 70% after the plan deductible is met
Inpatient hospital facility services		
Semi-private room and board and other non-physician services • Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc.	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Inpatient Professional Services • For services performed by surgeons, radiologists, pathologists and anesthesiologists	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Multiple surgical reduction • Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.	Included	Included
Outpatient services		
Outpatient surgery (facility charges)	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met

Benefits	In-network	Out-of-network
Outpatient Professional Services • For services performed by surgeons, radiologists, pathologists and anesthesiologists	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Physical, occupational, cognitive and speech therapy • Limited to 60 days per contract year for all therapies combined • Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy • Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehab therapy maximum.	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Cardiac rehabilitation • Limited to 36 days per contract year	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Chiropractic services • Limited to 24 days per contract year	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Outpatient Alternative Medical Services • Includes acupuncture/acupressure, biofeedback, naturopathic services, and other approved services when provided by a Designated Alternative Medicine Provider • Limited to 20 visits per contract year • No prior authorization required	You pay 10% Plan pays 90% after the plan deductible is met	Not Covered
Lab and X-ray		
Lab and X-ray • Physician's office • Outpatient hospital facility • Independent lab & x-ray facility	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Lab and X-ray, emergency room and urgent care • Emergency room when billed by the facility as part of the emergency room visit • Urgent care when billed by the facility as part of the urgent care visit. • Independent x-ray and/or lab facility in conjunction with a emergency room visit	You pay 10% Plan pays 90% after the in-network plan deductible is met	

Benefits	In-network	Out-of-network
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) • Physician's office • Inpatient hospital facility • Outpatient facility	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) • Emergency room • Urgent care facility	You pay 10% Plan pays 90% after the in-network plan deductible is met	
Emergency and urgent care services		
Hospital emergency room • Includes radiology, pathology and physician charges • Out-of-network services are covered at the in-network rate.	You pay 10% Plan pays 90% after the in-network plan deductible is met	
Ambulance • Out-of-network services are covered the same as in-network services. Note: Non-emergency transportation (e.g. from hospital back home) is generally not covered.	You pay 10% Plan pays 90% after the in-network plan deductible is met	
Urgent care services • Out-of-network services are covered at the in-network rate.	You pay 10% Plan pays 90% after the in-network plan deductible is met	
Other health care facilities		
Skilled nursing facility, rehabilitation hospital and other facilities • 90 days per contract year	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Home health care • Unlimited days per contract year	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Hospice • Inpatient services • Outpatient services	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Other health care services		
Durable medical equipment • Unlimited contract year maximum	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met

Benefits	In-network	Out-of-network
External prosthetic appliances (EPA) • Unlimited contract year maximum	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Bariatric Surgery • Treatment of clinically severe obesity, as defined by the body mass index (BMI) • Waiting Period: One year from date of initial Employment (to be verified by Maricopa County) • Inpatient hospital facility • Outpatient hospital facility • Physician services • Professional services *The following are excluded:* • *Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.*	You pay 10% Plan pays 90% after the plan deductible is met	Not Covered
TMJ	Not Covered	Not Covered
Maternity Care Services • Covers maternity for employee and all dependents.	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Infertility • Office visit for testing, treatment and artificial insemination • Inpatient hospital facility • Outpatient hospital facility • Physician services • Surgical treatment limited to procedures to correct infertility, excluding In-vitro, GIFT ZIFT, etc.	You pay 10% Plan pays 90% after the plan deductible is met	Not covered
Family planning • Inpatient hospital facility • Outpatient facility • Physician services • Surgical services such as tubal ligation or vasectomy are covered (excluding reversals). • Includes contraceptive devices	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met

Benefits	In-network	Out-of-network
Hearing services and Hearing Aids *Separate $2,000 Hearing Aid Maximum per ear per member every three years* *All providers covered*	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Homeopathic/Herbal Medical Products • Herbal and homeopathic products which are approved by the HEALTHPLAN are covered at no charge when obtained at the Designated Alternative Medicine Center • Contract year Maximum of $60	No charge	Not covered
Mental health and substance abuse services		
Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration: • Substance Abuse includes Alcohol and Drug Abuse services. • Transition of Care benefits are provided for a 90-day time period.		
Inpatient mental health services • Unlimited days per contract year • Mental health services are paid at 100% after you reach your out-of-pocket maximum.	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Outpatient mental health physician's office services • Unlimited visits per contract year • Mental health services are paid at 100% after you reach your out-of-pocket maximum. • This includes individual, group therapy mental health and intensive outpatient mental health	You pay 10% Plan pays 90% after the medical plan deductible is met	You pay 30% Plan pays 70% after the medical plan deductible is met
Outpatient mental health facility services • Unlimited visits per contract year • Mental health services are paid at 100% after you reach your out-of-pocket maximum. • This includes individual, group therapy mental health, and intensive outpatient mental health	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Inpatient substance abuse services • Unlimited days per contract year • Substance abuse services are paid at 100% after you reach your out-of-pocket maximum.	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Outpatient substance abuse physician's office services • Unlimited visits per contract year • Substance abuse services are paid at 100% after you reach your out-of-pocket maximum. • This includes individual and intensive outpatient substance abuse	You pay 10% Plan pays 90% after the medical plan deductible is met	You pay 30% Plan pays 70% after the medical plan deductible is met

Benefits	In-network	Out-of-network
Outpatient substance abuse facility services • Unlimited visits per contract year • Substance abuse services are paid at 100% after you reach your out-of-pocket maximum. • This includes individual and intensive outpatient substance abuse	You pay 10% Plan pays 90% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Prescription Drugs		
Cigna Pharmacy three-tier coinsurance plan • No mandatory generics • Self administered injectable– excludes infertility drugs • Includes Oral Contraceptives • Insulin pens and cartridges included	**Retail** (30 day supply) You pay: Generic 30% after plan deductible Preferred brand 40% after plan deductible Non-Preferred Brand 50% after plan deductible	Not Covered
Preventive Medications – Generic, Preferred Brand Name and Non-Preferred Brand Name Prescription medications used to prevent any of the following medical conditions are not subject to the deductible: Hypertension, High Cholesterol, Diabetes, Asthma, Osteoporosis, Stroke and prenatal nutrient deficiency. Consult the Cigna Website for more information on preventive medications	**Home Delivery** (90 Day supply) You pay: Generic 30% after plan deductible Preferred brand 40% after plan deductible Non-Preferred Brand 50% after plan deductible	
Pharmacy Clinical Management and Prior Authorization • Your plan is subject to certain clinical edits and prior authorization requirements.		
Clinical Outcome Programs • Includes complex psychiatric case management • Includes narcotic therapy management		

Specialty Pharmacy
• Clinical Programs
  ○ Prior authorization required on specialty medications and quantity limits may apply.
  ○ TheraCare® Program
• Medication Access Option: Retail and/or Home Delivery		

Benefits	In-network	Out-of-network
Vision care	Carved out to EyeMed	

Definitions

Coinsurance – After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called coinsurance.

Copay – A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

Cost and reimbursement vary based upon place of service – Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

Deductible – A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

Direct Access to Obstetricians and Gynecologists – You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card.

Out-of-pocket Maximum – Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "maximum reimbursable charges" or negotiated fees for covered services.

Pre-existing condition limitation – Not applicable to anyone under 19 years old. Applies to any injury or sickness that you are diagnosed with and receive treatment for, or incur expenses for during the 90 days before you are insured by these benefits or you begin an eligibility waiting period (whichever is earlier). Please refer to your plan documents for specific details.

Selection of a Primary Care Provider – Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

Transition of Care – Provides in-network health coverage to new customers when the customer's doctor or facility is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor and/or remain in the same facility.

Maximizing your health care dollars

Log on to myCigna.com for resources to help you choose a health care professional or compare the cost and quality of medical services, medications and hospital care.

When you need a medical service or procedure, Cigna offers you opportunities to save on prescription medicine, routine medical care, laboratory services, radiology scans, and outpatient surgery. Details are below:

Cigna Home Delivery Pharmacy –You can save money and enjoy convenient home delivery by using Cigna Home Delivery Pharmacy for your prescription medications. You can get up to a 90-day supply of your medication.

Lab – Save on lab services by using a free-standing laboratory instead of a hospital- or clinic-based lab.

Urgent Care – For non-emergency conditions that need attention before you can see your doctor, you can save money by going to an urgent care center instead of an Emergency Room (ER).

Convenience Care – For minor or routine conditions, go to a Convenience Care Clinic when your doctor is unavailable. Convenience Care Clinics are retail-based and often found in pharmacies or grocery stores.

Radiology – Costs for MRIs, PET, and CT scans can vary greatly. Non-hospital based outpatient radiology centers often cost much less than a hospital. Cigna's network includes both hospitals and outpatient centers, so you can find a radiology center that's right for you.

Outpatient Surgery – Costs for colonoscopies, arthroscopies, and other outpatient procedures can vary greatly. Using a free-standing outpatient surgery center can save hundreds of dollars.

Exclusions

What's Not Covered (*not all-inclusive*):

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Services provided through government programs
- Services that aren't medically necessary
- Experimental, investigational or unproven services
- Services for an injury or illness that occurs while working for pay or profit including services covered by Worker's Compensation benefits
- Cosmetic services
- Dental care, unless due to accidental injury to sound natural teeth
- Reversal of sterilization procedures
- Genetic screenings
- Non-prescription and anti-obesity drugs
- Custodial and other non-skilled services
- Weight loss programs
- Treatment of TMJ Disorder
- Treatment of sexual dysfunction
- Travel immunizations
- Eyeglass lenses and frames, contact lenses and surgical vision correction

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

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